



LABORATORY SELECTION FORM

Public Water Supplier: _____

Owner: _____

Address of facility: _____

PWS # ___not yet assigned_____

Please sign this form and return to the address below or fax to 401-222-6953:

Rhode Island Department of Health
Attn: Compliance Manager
Three Capitol Hill, Room 209
Providence, R.I. 02908-5097

I will utilize the services of the following Rhode Island Licensed Laboratory for all parameters, or, for the following specific parameter(s) listed below: **Total/ Fecal Coliform Bacteria, nitrates and nitrites.**

Laboratory Name: _____

Laboratory Address: _____

Specific Parameters: _____

(List the specific parameter(s) for each laboratory. Be sure to list all required parameters.) Please use the back side of this form if additional space is needed.

Signature of Purveyor: _____ Date: _____

PLEASE NOTE THAT YOU ARE RESPONSIBLE FOR INSURING THAT ALL MONITORING REQUIREMENTS ARE MET.

If you have any questions please contact Fred Kurdziel at 222-7787. Thank you.